Momentous Changes to Maternity Care Services

Nancy J. Andersen, MS, RHIA, CCS,CRC
Consultant, Acuvance Coker

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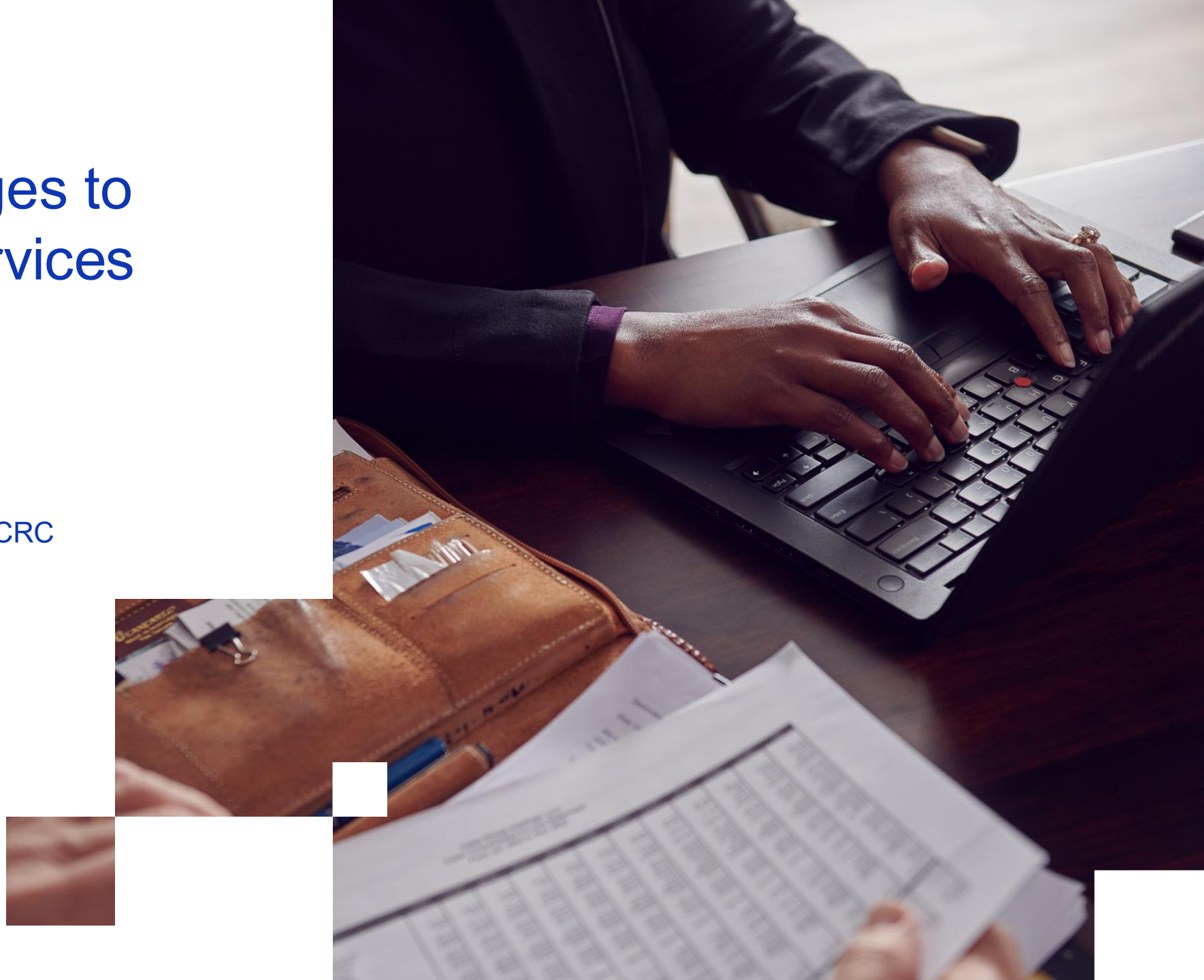

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About the Presenter

Nancy J. Andersen, MS, RHIA, CCS, CRC
Consultant, Acuvance Coker

Ms. Andersen is an independent consultant for Acuvance Coker (formerly Healthcare Cost Solutions), with over 40 years of experience in Health Information Management (HIM).

Ms. Andersen is a past member of the American Health Information Association (AHIMA) board of directors 2021-2024; served as President for the California Health Information Association (CHIA), and Director on the Board of Directors for (CHIA).

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Goals and Objectives

- Discover the key changes to Maternity Care professional services effective Jan. 1, 2027.
- Enhance understanding of the rationale behind adoption of new Maternity Care guidelines and CPT codes.
- Review impact of phased Maternity Care on revenue workflow.
- Identify and review case examples using the new coding and billing requirements for maternity care.

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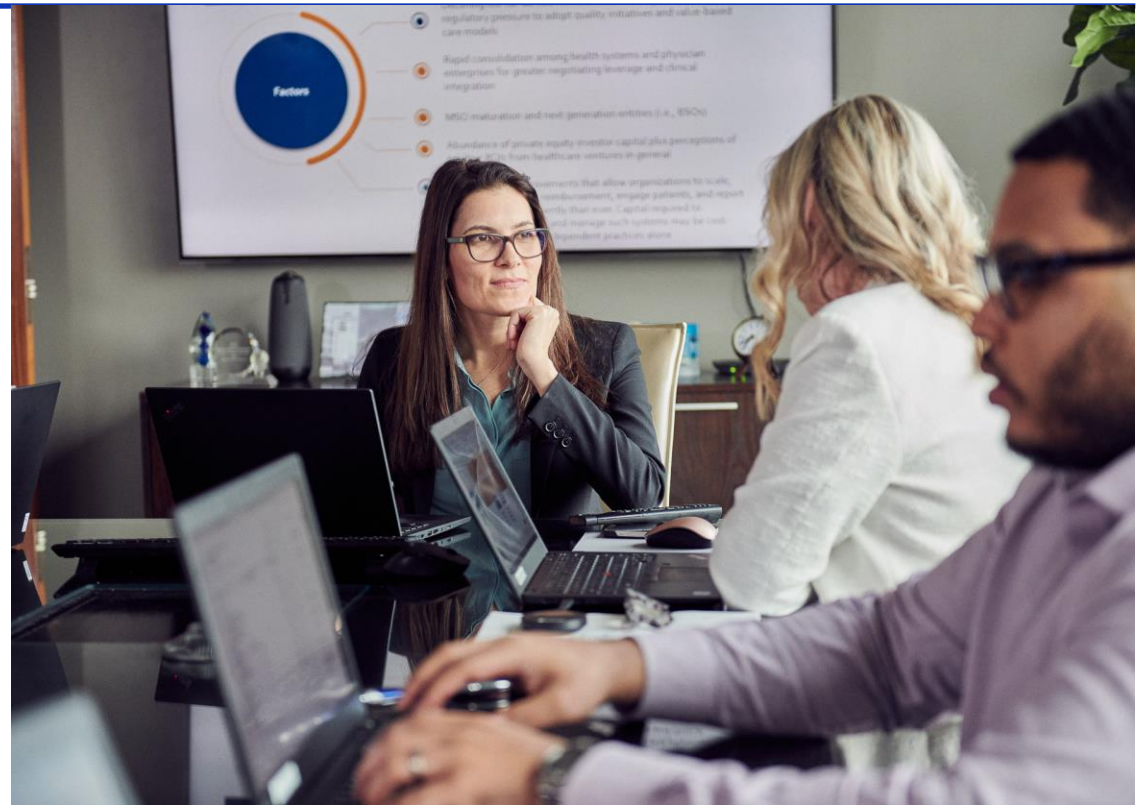
Agenda

I. Introduction, rationale and clinical insights

II. Changes to maternity care coding guidelines

III. Changes to specific CPT codes

IV. Budget Implications



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Introduction, Rationale and Clinical Insights



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Introduction: The Restructuring of Maternity Care

- The American Medical Association (AMA) significantly restructured how maternity care services are reported. The new codes “will better reflect modern obstetric practice, enable accurate and transparent reporting across the full pregnancy spectrum, and create the data foundation necessary to better attribute maternal care and support the complexities of team-based care throughout a patient's journey”[1].

- Effective January 1, 2027, the Current Procedural Terminology ® (CPT) maternity care section will transition from coding based on the traditional global maternity care package to coding each obstetric phase encounter separately.

- This revision affects 35 codes:
  - 17 codes will be deleted
  - 12 codes will be added
  - 6 codes will be revised.

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[1] https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes

Rationale and Clinical Insights

- Better reflects the current model of maternity care in the U.S.
  - Aligns with newly published Clinical Consensus for Tailored Prenatal Care Delivery for Pregnant Individuals[1].
- Improves transparency, data quality and measurement of services provided.
  - Payors and healthcare systems will gain improved visibility into real-world care delivery and data collection.
- Supports evidence-based labor and postpartum care services.
  - Aligns with the actual time and intensity of today's labor and delivery services.
  - Reflects expanded monitoring of postpartum conditions.

[1] American College of Obstetrics & Gynecology. *Tailored Prenatal Care Delivery for Pregnant Individuals*. https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2025/04/tailored-prenatal-care-delivery-for-pregnant-individuals

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New “Obstetric Phases” of Care

- The new obstetric phases include:
  - **Antepartum care**: reported per encounter using the appropriate evaluation and management service under standard E/M rules (medical decision making or total time).
  - **Labor management**: Distinguishes initial and subsequent days and straightforward versus complex care management.
  - **Delivery**: Separately describes vaginal, vaginal delivery after c-section (VBAC), primary cesarean, and repeat cesarean delivery care.
  - **Postpartum care**: Includes routine same-day care as part of delivery care reporting. Subsequent inpatient care and outpatient postpartum services are reported using the applicable E/M codes.

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Changes to Maternity Care Coding Guidelines and CPT Codes: Antepartum Visits



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2026 Global Maternity Care Guidelines Compared to 2027 Antepartum Guidelines

2026 Obstetric Global Guidelines (59400, 59510; 59610)

- Antepartum care includes:
  - Monthly visits for up to 28 weeks gestation
    - Initial prenatal H&P
    - Subsequent H&Ps
    - Recording of vitals, fetal heart tone, routine labs
  - Biweekly visits to 36 weeks
  - Weekly visits until delivery
  - Any other visits or services within the antepartum period are reported separately.

2027 Obstetric Phase Guidelines (reported individually)

- Antepartum care:
  - Report each visit* using the appropriate evaluation and management service under standard E/M rules of either medical decision-making or total time.
  - Antepartum and fetal invasive procedures may be separately reported from antepartum evaluation and management (E/M) visits, including any diagnostic imaging services (eg, obstetrical ultrasound evaluation of the fetus[es] including maternal pelvis and placenta, fetal magnetic resonance imaging) may be separately reported in addition to antepartum E/M visits.

*ACOG recommendation: “OG-GYNs and other maternity care professionals **may tailor the visit frequency and monitoring schedule as determined by the medical and social needs of the pregnant individual.”**

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Antepartum Office Visit Codes and RVUs

New Patient Office Visit	Work RVU	Est. Patient Office Visit	Work RVU
		99211	0.18
99202	0.93	99212	0.70
99203	1.60	99213	1.30
99204	2.60	99214	1.92
99205	3.50	99215	2.80

- Append E/M codes (99202-99215; 99341-99350) with modifier –TH, *Obstetrical treatment/services, prenatal or postpartum*, to indicate it is an antepartum visit. The E/M level is *not* "fixed" for the entire prenatal phase of care.

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E/M Level for Prenatal Visits

- When individual prenatal visits are reported using E/M codes, Medical Decision Making (MDM) *or* Total Time may be used to determine the level like any other E/M encounter.

- For the purposes of E/M reporting using MDM, pregnancy is reported as a "problem addressed" during a prenatal visit.

- A normal uncomplicated pregnancy is considered a "chronic illness with exacerbation, progression, or side effects of treatment" and best fits into the moderate category of a problem addressed.[2] It is not considered an acute, uncomplicated illness.

[2]CPT Assistant, June 2026. *Antepartum Care: Changes for 2027*.

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Case Example: Routine Prenatal Visit

- An established patient comes in for a standard 24-week check. The pregnancy is stable and progressing normally. Patient reports feeling well with no complaints. No other conditions are addressed during the visit.

- Vital signs are normal, fetal heart tones are positive, and fundal height matches. The provider reviews routine lab results ordered during the last visit which are noted to be within normal range. Routine prenatal counseling (nutrition, kick counts) is provided. No new labs were ordered. No medication management is required during the visit. Total time is documented as 15 minutes.

- MDM: Number and complexity of problems addressed: Moderate, 99214
- Amount and/or complexity of data reviewed: Straightforward, 99212
- Risk of complications or morbidity/mortality of patient management: Straightforward, 99212
- Visit complexity supports 99212.

- Total Time of 15 minutes supports 99212

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Case Example: Prenatal Visit with Stable Chronic Issue

- An established patient at 28 weeks presents for a routine prenatal check. Patient and physician discuss patient's mild chronic hypertension (controlled). Patient is reassured that hypertension medication will not affect the fetus.

- Vital signs are normal, fetal heart tones are positive, and fundal height matches. The provider reviews routine lab results ordered during the previous visit, current medications with prescription renewal, and provides routine prenatal counseling. A CBC and fetal non-stress test are ordered. Total time is documented as 22 minutes.

- MDM:
  - Number and complexity of problems addressed: Moderate, 99214
  - Amount and/or complexity of data reviewed: Low, 99213
  - Risk of complications or morbidity/mortality of patient management: Low, 99214
  - Visit complexity supports 99214.

- Total Time of 22 minutes supports 99213

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Case Example: Prenatal Visit with Moderate-Complexity Complication or New/Exacerbated Problem

- An established patient presents for a routine 24-week prenatal check. Upon review of recent labs the patient is diagnosed with gestational diabetes.

- Vital signs are normal, fetal heart tones are positive, and fundal height matches. Recently completed labs are reviewed with the patient and new CBC and blood glucose tests are ordered. A fetal non-stress test is ordered. Patient is placed on a diabetic diet and low-dose medication to treat the gestational diabetes. Patient receives counseling regarding gestational diabetes and possible future care requirements. Total time is documented as 32 minutes.

- MDM:
  - Number and complexity of problems addressed: Moderate, 99214
  - Amount and/or complexity of data reviewed: Moderate, 99214
  - Risk of complications or morbidity/mortality of patient management: Moderate, 99214
  - Visit complexity supports 99214.

- Total Time of 32 minutes supports moderate, 99214

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Case Example: High-Complexity Prenatal Visit / Intensive Management

- An established patient presents to the office for a prenatal visit at 28 weeks. Patient exhibits signs and symptoms of severe preeclampsia. Vital signs show a blood pressure with reading of 145/95. A medically appropriate H&P is performed, and decision is made to coordinate immediate hospital admission. Total time is documented as 45 minutes.

- MDM:
  - Number and complexity of problems addressed: High, 99215
  - Amount and/or complexity of data reviewed: Straightforward, 99212
  - Risk of complications or morbidity/mortality of patient management: High, 99215
  - Visit complexity supports 99215.

- Total Time of 45 minutes supports 99215

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Changes to Maternity Care Coding Guidelines and CPT Codes: Labor Services



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2026 Global Maternity Care Guidelines Compared to 2027 Labor and Delivery Guidelines

2026 Obstetric Global Guidelines (59400, 59510; 59610)

- Delivery services include:
  - Hospital admission
  - Admission H&P
  - Management of uncomplicated labor
  - Vaginal delivery (with/without episiotomy, and/or forceps) or C-section delivery

2027 Obstetric Phase Guidelines (59080-59083)

- Labor Management:
  - Report labor management for the initial day and each subsequent day
  - Report labor management as either straightforward or complex based on criteria of services provided
- Delivery Services:
  - Report delivery separately; vaginal, primary C-section or repeat C-section

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Labor Management Coding Guidelines

- Labor management involves integrated decision making to assess, support, and balance the well-being of the patient in labor and fetus(es), including managing medical conditions or complications.

- Interim physical examinations and collection and interpretation of physiologic data, and induction/augmentation of labor are included in labor management and are not separately reported.

- Labor management code requirements:
  - A face-to-face encounter with the mother
  - Reported once per calendar date regardless of the number of fetuses.
  - Multiple visits by the same physician or other QHP or same group practice over the course of a single calendar date in the same setting are reported as a single labor management service.
  - A continuous visit that spans two calendar dates is considered a single service and is reported as a single service on one of the two calendar dates.
  - When a physician or other QHP, regardless of specialty or group, is on call for or covering for another physician or other QHP, the patient's encounter will be coded as it would have been by the physician or other QHP who is not available.
  - When APPs (certified nurse midwives) and PAs are working with physicians, they are considered working in the same specialty and subspecialty as the physician.

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Determining Labor Management Complexity

- Labor complexity consists of two levels of labor management: straightforward and complex.
- For reporting purposes, the level of labor management is based on the condition of the mother and fetus(es) and the complexity of medically necessary medical decision making and associated services.
- Report the highest level of labor management performed once per calendar date.
- The duration of labor does not indicate the complexity of labor management, unless prolonged labor is diagnosed.
- When the physician or other QHP is consulted during labor management but does not assume care for the mother or fetus(es), the consultant may report their services with E/M codes, such as synchronous audio-video E/M, initial hospital inpatient/observation care, inpatient/observation consultation, or interprofessional telephone/internet/electronic health record.

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Levels of Labor Management

Straightforward	Complex
If all the following criteria below are *not met*, labor management is considered complex:	Any labor management that is not explicitly defined as straightforward in this table.
• Single fetus in a vertex presentation • Routine maternal/fetal monitoring • Fetal monitoring not requiring physician or other QHP intervention • Normal progression of labor or routine labor induction or augmentation • Stable medical conditions (eg, well-controlled hypertension, diet-controlled diabetes) not requiring additional management during labor • No previous cesarean delivery	*Examples*: • More than one fetus • Fetal monitoring abnormalities requiring a change in management requiring physician or other QHP intervention • Prolonged first or second stage of labor • Labor complications • One or more severe maternal morbidity indicator(s) • Maternal medical conditions requiring additional medical management during labor • Previous cesarean delivery

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New Labor Management CPT ® Codes

CPT Code	Code Description	Work RVU
59080	Initial day labor management; straightforward, per day ►(Do not report 59080 in conjunction with 59081, for the same calendar date)◄ ►(Do not report 59080 in conjunction with 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236)◄	4.03
59081	complex, per day ►(Do not report 59081 in conjunction with 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236)◄	5.18
59082	Subsequent day labor management; straightforward, per day ►(Do not report 59082 in conjunction with 59083, for the same calendar date)◄	3.45
59083	complex, per day ►(Do not report 59082, 59083 in conjunction with 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236)◄	4.83

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Labor Management – Initial Day

- Initial day labor management includes the E/M work for admission to the facility.
- Initial day labor management may only be reported once per setting using the highest level (straightforward or complex) of labor management provided on that calendar date.
- When the mother is admitted to the facility for labor management in the course of an encounter in another (initial) site of service (eg, hospital ER, physician office), the E/M service in the initial site may be separately reported.
  - Modifier 25 may be added to the E/M service to indicate a significant, separately identifiable service by the same physician or other QHP was performed on the same calendar date as the initial day of labor management.

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Labor Management – Initial Day Criteria

- Initial labor management may only be reported when one of the following criteria is met:
  - The first calendar date the mother requires labor management services or induction begins;
  - The physician or other QHP or same group practice has not previously performed labor management services during the same facility admission and stay;
  - The mother is transferred to a new facility after receiving labor management services at the previous facility; or a physician or other QHP of a different specialty or subspecialty assumes care for reasons other than covering for another physician or other QHP (escalation of care for medical necessity).
    - If no criterion above is met, subsequent day labor management (59082, 59083) is reported.

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Labor Management – Subsequent Day Criteria

- Subsequent day labor management may be provided on multiple calendar dates, provided the treatment by the physician or other QHP is intended to result in delivery.

- Subsequent labor management may be reported once per calendar date using the highest level (straightforward or complex) of labor management services provided on each calendar date subsequent to the initial day labor management service calendar date and the encounter does not meet criteria for reporting initial day labor management services.

- Subsequent labor management may be reported on the calendar date of delivery if labor management services were performed.

- Subsequent day labor management may not be reported on the same calendar date as the initial day labor management service.

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Changes to Maternity Care Coding Guidelines and CPT Codes: Delivery Services



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Vaginal Delivery Coding Guidelines

- Delivery care begins when labor is complete or interrupted (eg, arrest of labor is diagnosed and a subsequent decision for cesarean delivery is made). Vaginal and cesarean delivery care does not include the work of labor management. Delivery care includes management of the mother and fetus(es).

- Immediate (same calendar date) postpartum care is considered part of delivery care services and is not reported separately. When a patient is discharged on the same calendar date as delivery care, do not separately report hospital inpatient or observation discharge day management services (99238, 99239).

- When postpartum care takes place on a calendar date subsequent to the date of reported delivery care services, report the appropriate E/M code.

- A breech vaginal delivery may be reported with a vaginal delivery code (59431, 59432) with modifier 22.

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New Vaginal Delivery CPT ® Codes

CPT Code	Code Description	Work RVU
59431	Vaginal delivery, with or without episiotomy;	9.20
59432	after previous cesarean delivery	10.35
59414	Delivery of placenta only (separate procedure) ►(Do not report 59414 in conjunction with 59431, 59432)◄	1.61
59300	Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure) ►(Do not report 59300 in conjunction with 59431, 59432)◄	1.76
59433	Repair of episiotomy or laceration; third-degree laceration	2.47
59434	fourth-degree laceration ►(For repair of third- or fourth-degree episiotomy or laceration, use 59433, 59434 in conjunction with 59431, 59432, when performed at the time of vaginal delivery)◄	4.14

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Cesarean Delivery Coding Guidelines – Primary CS

- A primary cesarean delivery is typically an unplanned event following labor. An unscheduled or unplanned cesarean delivery in a laboring patient (expected vaginal delivery) begins at the decision for cesarean delivery and may be reported in conjunction with labor management services (59081, 59083).

- For any planned or scheduled primary cesarean delivery that occurs without labor, an E/M service, such as an initial or subsequent hospital inpatient or observation care service may be separately reported on the same calendar day when performed. A labor management code is not separately reported.

- Cesarean deliveries include delivery of the fetus(es), placenta(s), and closure of the uterine and abdominal incisions.

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Cesarean Delivery Coding Guidelines – Primary CS (cont.)

- Report only one cesarean delivery code for multiple gestations. To report a fetus(es) delivered vaginally and a fetus(es) delivered via cesarean delivery for the same patient, use the appropriate delivery code per fetus delivered vaginally and the appropriate cesarean delivery code once, regardless of the number of fetuses delivered via cesarean delivery.

- When a hysterectomy is performed during the same operative session as a cesarean delivery, assign code 59504, *Subtotal or total hysterectomy after cesarean delivery*.

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Cesarean Delivery Coding Guidelines – Repeat CS

- A repeat cesarean delivery is reported for a patient who has had a previous CS. An unscheduled or unplanned cesarean delivery in a laboring patient (expected vaginal delivery) begins at the decision for CS and may be reported in conjunction with labor management services (59081, 59083).

- A repeat cesarean delivery (59503) is typically a planned event without labor, and as such, initial or subsequent hospital inpatient or observation care services (99221, 99222, 99223, 99231, 99232, 99233) are included and may not be separately reported on the same calendar date as a repeat cesarean delivery.

- For cesarean delivery of multiple gestations, report only one cesarean delivery code (59502, 59503).

- When a subtotal or total hysterectomy is performed during the same operative session as a cesarean delivery, use 59504. The hysterectomy may be performed by the same or different physician performing the cesarean delivery

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New Cesarean Delivery CPT ® Codes

CPT Code	Code Description	Work RVU
59502	Cesarean delivery; primary	13.80
59503	Cesarean delivery; repeat	16.86
59504	Subtotal or total hysterectomy after cesarean delivery ►(When the same physician performs both the cesarean delivery and hysterectomy, report 59504 with modifier 51)◄ ►(For ligation or transection of fallopian tube[s] performed at the time of subtotal or total hysterectomy, use 58611)◄ ►(For subtotal or total hysterectomy performed during the same operative session as the cesarean delivery, use 59504)◄ ►(59510 has been deleted. For antepartum care, see the appropriate E/M code[s]. For labor management, see 59080, 59081, 59082, 59083. For cesarean delivery, see 59502, 59503. For postpartum care, see the appropriate E/M code[s])◄ ►(59514, 59515 have been deleted. For cesarean delivery services, see 59502, 59503. For postpartum care, see the appropriate E/M code[s])◄ ►(59525 has been deleted. To report, use 59504)◄	15.56

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Changes to Maternity Care Coding Guidelines and CPT Codes: Postpartum Services



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2026 Global Maternity Care Guidelines Compared to 2027 Postpartum Guidelines

2026 Obstetric Global Guidelines (59400, 59510; 59610)

- Postpartum care:
  - Includes synchronous audio-video visits, synchronous audio-only visits, brief communication technology-based services, or office or other outpatient visits following vaginal or C-section delivery.

2027 Obstetric Phase Guidelines (reported individually)

- Postpartum care:
  - Routine immediate same calendar day postpartum care is included as part of delivery reporting and not reported separately.
  - Subsequent inpatient and outpatient services use the applicable E/M codes.
  - Maternal postpartum care includes ongoing assessments tailored to the individual patient.

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Maternal Postpartum Care Guidelines

- Postpartum care is reported as an evaluation and management (E/M) service.
  - Inpatient postpartum care on a calendar date other than the delivery date, may be reported with an E/M service, such as subsequent hospital inpatient or observation care service, inpatient or observation discharge service or critical care service.
  - For outpatient postpartum care on a calendar date subsequent to delivery care, report the appropriate E/M service (eg, office or other outpatient service), telemedicine service, virtual check-in, home or residence service.

- Do not report hospital inpatient or observation care services, or hospital inpatient or observation discharge services for maternal postpartum care on the same calendar date as delivery care.

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Case Example: Straightforward Postpartum Visit

- An established patient presents for a brief routine, follow-up postpartum visit at two weeks. Patient is healing well with no complications. A medically appropriate physical exam, check of vital signs, and check on a well-healing vaginal laceration is performed. No labs or new prescriptions ordered. Routine guidance on sleeping and activity limits is provided. Total time is documented as 14 minutes.

- MDM:
  - Number and complexity of problems addressed: Moderate, 99214
  - Amount and/or complexity of data reviewed: Straightforward, 99212
  - Risk of complications or morbidity/mortality of patient management: Straightforward, 99212
  - Visit complexity supports 99212.

- Total Time of 14 minutes supports 99212

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Case Example: Low Complexity Postpartum Visit

- An established patient presents for her 6-week postpartum visit following repeat CS.
- History & Exam: Review of general physical recovery, bladder/bowel function, evaluation of incision, mood/sleep evaluated, and depression screening is performed. Patient was provided with routine contraceptive counseling and prescription for birth control. Total time of visit is documented as 20 minutes.

- MDM:
  - Number and complexity of problems addressed: Moderate, 99214
  - Amount and/or complexity of data reviewed: Straightforward, 99212
  - Risk of complications or morbidity/mortality of patient management: Low, 99213
  - Visit complexity supports 99213.

- Total Time of 20 minutes supports 99213

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Case Example: Moderate Complexity Postpartum Visit

- An established patient presents for a routine, follow-up postpartum visit at two weeks. Patient is experiencing moderate anxiety/depression symptoms (e.g., elevated EPDS score).

- A medically appropriate H&P is performed with examination of patient's perineal laceration repair. Perineal wound shows evidence of localized wound infection requiring antibiotics. A detailed history of emotional health is performed. Referral is made to social services for postpartum depression and medication prescribed. Total time excluding depression screening is noted as 35 minutes.

- MDM:
  - Number and complexity of problems addressed: Moderate, 99214
  - Amount and/or complexity of data reviewed: Straightforward, 99212
  - Risk of complications or morbidity/mortality of patient management: Moderate, 99214
  - Visit complexity supports 99214.

- Total Time of 35 minutes supports 99214

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Case Example: High Complexity Postpartum Visit

- An established patient presents for a routine, follow-up postpartum visit at 10 days. The patient is experiencing symptoms of postpartum preeclampsia with severe headaches and shortness of breath.

- A medically appropriate H&P is performed. Check of vital signs documents patient's BP at 150/98. Patient is diagnosed with postpartum preeclampsia, and arrangements are made for immediate admission to the hospital. Total time is documented as 50 minutes.

- MDM:
  - Number and complexity of problems addressed: High, 99215
  - Amount and/or complexity of data reviewed: Straightforward, 99212
  - Risk of complications or morbidity/mortality of patient management: High, 99215
  - Visit complexity supports 99215

- Total Time of 50 minutes supports 99215.

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Impact of Changes to Maternity Care Services



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Transition to New Maternal Care Coding Guidelines

- The new maternity care coding structure does not apply to services provided before Jan. 1, 2027.
- Antepartum care delivered in 2026 must continue to be reported under the 2026 CPT guidelines, even when the pregnancy extends into 2027.
  - For 1-3 antepartum visits in 2026 – report the appropriate E/M outpatient visit
  - For 4-6 antepartum visits in 2026 – report 59425
  - For 7 or more antepartum visits in 2026 – report 59426
- Practices should report antepartum care separately for each calendar year using the codes and guidelines in effect when the services were provided.

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Physician Practice Impact

- Currently, the CPT code for the global package is submitted after delivery. The practice receives one payment for the entire pregnancy episode.
  - Under obstetric-phase reporting, the practice bills for care as it is delivered. This means a change to cash-flow timing, claim submission volume, and the amount of documentation required to support each claim.

- Transfer of care will be impacted. Today, a patient who moves between practices during pregnancy triggers an unbundling exercise.
  - Moving forward, each practice will report the visits it provides. Practices that refer high-risk patients out will see the effect of that decision on the claim rather than at the end of the pregnancy.

- This transition between payment structures may pose an operational risk. A practice will be working the two structures at once for some period, because payers will not move on the same date, and pregnancies in progress on Jan. 1st will span both payment structures.

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Determine Each Phase of Obstetric Work Attribution

- Discrete work attribution will drive revenue. How is the professional work of maternity care performed across the continuum of care in your organization or practice?
  - Professional services; OB-GYNs, Mid-Wives; Advanced Practice Providers
  - Team-based care
  - Cross-coverage

- The shift in coding and billing of maternity care services will require a detailed understanding of how your existing care model(s) will perform under the new maternity care model based on obstetric-phase coding and billing.

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Potential Budget Impact

- The AMA/Specialty Society RUC Committee analyzed a survey of over 650 physicians and nurse midwives to determine the time and intensity of obstetric-phase approach.

- Using CDC information and payer data, the RUC analyzed its recommendations and affirmed that if adopted, the relative value units (RVUs) in total for the new codes will not exceed the RVUs of the former bundled/global codes.

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Payor Adoption of New Maternity Care Model

- Med-QUEST beneficiaries are enrolled in managed care plans, the largest being HMSA (which handles a massive portion of the state's Medicaid and commercial population).
- HMSA has stated it is adopting the unbundled CPT 2027 code set for its commercial lines, standardizing its internal claims editing engines to use the same CPT structure for its Med-QUEST plans.
- This will prevent providers from having to navigate dual billing systems should CMS choose to move forward with the global HCPCS codes rather than adopting the new AMA recommendations for maternity care.

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Summary

- Practices and health care organizations should obtain each payer's written effective date, modifier instructions, claim examples, and fee schedule before changing maternity and delivery care billing workflows.
  - A CPT effective date does not, by itself, establish every payer's modifier, fee schedule, claim-editing, or cross-year payment policy.
  - Maintain a payer-by-payer implementation record and update it as written guidance is issued.
  - Understand how each payer will handle transition year pregnancies under the new guidelines.
- The goal for these changes is to allow more comprehensive and tailored billing of services provided for obstetric payments, including person-centered prenatal care, social needs screening and management, and telemedicine and home monitoring.

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Questions



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Appendix – Useful Information and Tools

- Deleted 2026 CPT codes
- Comparison of RVUs for 2026 Maternity Care Global Services codes vs. 2027 CMS proposed global HCPCS codes.
- Criteria for use of Medical Decision Making (MDM) in assignment of evaluation and management level (E/M) services.
- Criteria for use of Total Time in assignment of E/M level services.

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Deleted Maternal Care CPT Codes

CPT Code	Code Description
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; S&I
59400	Routine OB care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy, and/or forceps)
59410	including postpartum care
59425	Antepartum care only; 4-6 visits
59426	7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine OB care including antepartum care, cesarean delivery (with or without episiotomy, and/or forceps) and postpartum care
59514	Cesarean delivery only
59515	including postpartum care

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Deleted Maternal Care CPT Codes (cont.)

CPT Code	Code Description
+59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
59610	Routine OB care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps);
59614	including postpartum care
59618	Routine OB care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
59622	including postpartum care

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Comparison of 2026 Maternity Care RVUs to Proposed 2027 CMS Maternity Care HCPCS RVUs

CPT Code	CPT Work RVU	HCPCS Code	HCPCS Work RVU	Code Description
59400	37.0	GMAT1	37.0	Routine OB care including antepartum care, vaginal delivery (with/without episiotomy, and/or forceps) and postpartum care
59409	14.37	GMAT2	14.37	Vaginal delivery only (with/without episiotomy, and/or forceps)
59410	18.76	GMAT3	18.76	Vaginal delivery only (with/without episiotomy, and/or forceps); including postpartum care
59425	7.80	GMAT4	7.80	Antepartum care only; 4-6 visits
59426	14.30	GMAT5	14.30	Antepartum care only; 7 or more visits
59430	3.22	GMAT6	3.22	Postpartum care only (separate procedure)
59510	41.05	GMAT7	41.05	Routine OB care including antepartum care, C-section delivery and postpartum care
59514	16.13	GMAT8	16.13	C-section delivery only
59515	22.79	GMAT9	22.79	C-section delivery only; including postpartum care

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Comparison of 2026 Maternity Care RVUs to Proposed 2027 CMS Maternity Care HCPCS RVUs (cont.)

CPT Code	CPT Work RVU	HCPCS Code	HCPCS Work RVU	Code Description
59610	38.71	GMAT10	38.71	Routine OB care including antepartum care, vaginal delivery (with/without episiotomy, and/or forceps) and postpartum care; after previous C-section delivery
59612	16.09	GMAT11	16.09	Vaginal delivery only, after previous C-section delivery (with/without episiotomy, and/or forceps)
59614	20.48	GMAT12	20.48	Vaginal delivery only, after previous C-section delivery (with/without episiotomy, and/or forceps); including postpartum care
59618	41.57	GMAT13	41.57	Routine OB care including antepartum care, C-section delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	16.66	GMAT14	16.66	Cesarean delivery only, following attempted vaginal delivery after previous C-section
59622	23.32	GMAT15	23.32	C-section delivery only, following attempted vaginal delivery after previous C-section; including postpartum care

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Medical Decision Making (MDM)

- MDM is defined by three elements:
  1. The number and complexity of problem(s) addressed during the encounter;
  2. The amount and/or complexity of data reviewed and analyzed;
  3. The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problems, the diagnostic procedure(s), treatment.

- The E/M level is assigned based on meeting the criteria for 2 out of the 3 elements of MDM.

- The same MDM criteria is also used for professional services E/M assignment for consults, inpatient and observation services.

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MDM: Number and Complexity of Problems Addressed During the Encounter – Condition/Illness Classifications

Straightforward	Low	Moderate	High
1 self-limited or minor problem	2 or more self-limited or minor problems; **Or** 1 stable chronic condition; **Or** 1 acute uncomplicated illness or injury; **Or** 1 stable acute illness; **Or** 1 acute uncomplicated illness or injury requiring hospital inpatient or observation level of care	1 or more chronic conditions with exacerbation, progression, or side effects of treatment; **Or** 2 or more stable chronic conditions; **Or** 1 undiagnosed new problem with uncertain prognosis; **Or** 1 acute illness with systemic symptoms; **Or** 1 acute complicated injury	1 or more chronic conditions with severe exacerbation, progression, or side effects of treatment; **Or** 1 acute or chronic illness or injury that poses a threat to life or bodily function

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MDM: Amount and/or Complexity of Data Reviewed and Analyzed

Straightforward	Low	Moderate	High
Minimal or None	Limited (***Must meet the requirements of at least 1 out of 2 categories***) Category 1: Any combination of 2 from the following: • Review of prior external note(s) from each unique source* • Review of the result() of each unique test* • Ordering of each unique test* **Or** Category 2: Assessment requiring an independent historian(s) (*For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high*)	Moderate (***Must meet the requirements of at least 1 out of 3 categories***) Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source* • Review of the result(s) of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of a test performed by another physician/other QHCP (not reported separately) **Or** Category 3: Discussion of management or test interpretation with external physician/other QHCP/appropriate source (not separately reported)	Extensive (***Must meet the requirements of at least 2 out of 3 categories***) Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source* • Review of the result() of each unique test* • Ordering of each unique test* • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of test(s) performed by another physician/other QHCP (not reported separately) **Or** Category 3: Discussion of management or test interpretation with external physician/other QHCP/appropriate source (not separately reported)

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MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

Straightforward	Low	Moderate	High
Minimal risk of morbidity from additional diagnostic testing or treatment	Low risk of morbidity from additional diagnostic testing or treatment	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

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Total Time for E/M Office/Outpatient Visits

- When coding is based on time, documentation needs to tell the story of the face-to-face and non-face-to-face activities.

- Supporting documentation needs to explain what filled that time and why it was necessary.

New Patient	Time	Established Patient	Time
99202	15 minutes met or exceeded	99211	N/A
99203	30 minutes met or exceeded	99212	10 minutes met or exceeded
99204	45 minutes met or exceeded	99213	20 minutes met or exceeded
99205	60 minutes met or exceeded	99214	30 minutes met or exceeded
		99215	40 minutes met or exceeded
99417	75 minutes met or exceeded	99417	55 minutes met or exceeded

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ACUVANCE COKER CONTACT

[Contact Name], [Title]
[email]@cokergroup.com

Headquarters Office Location

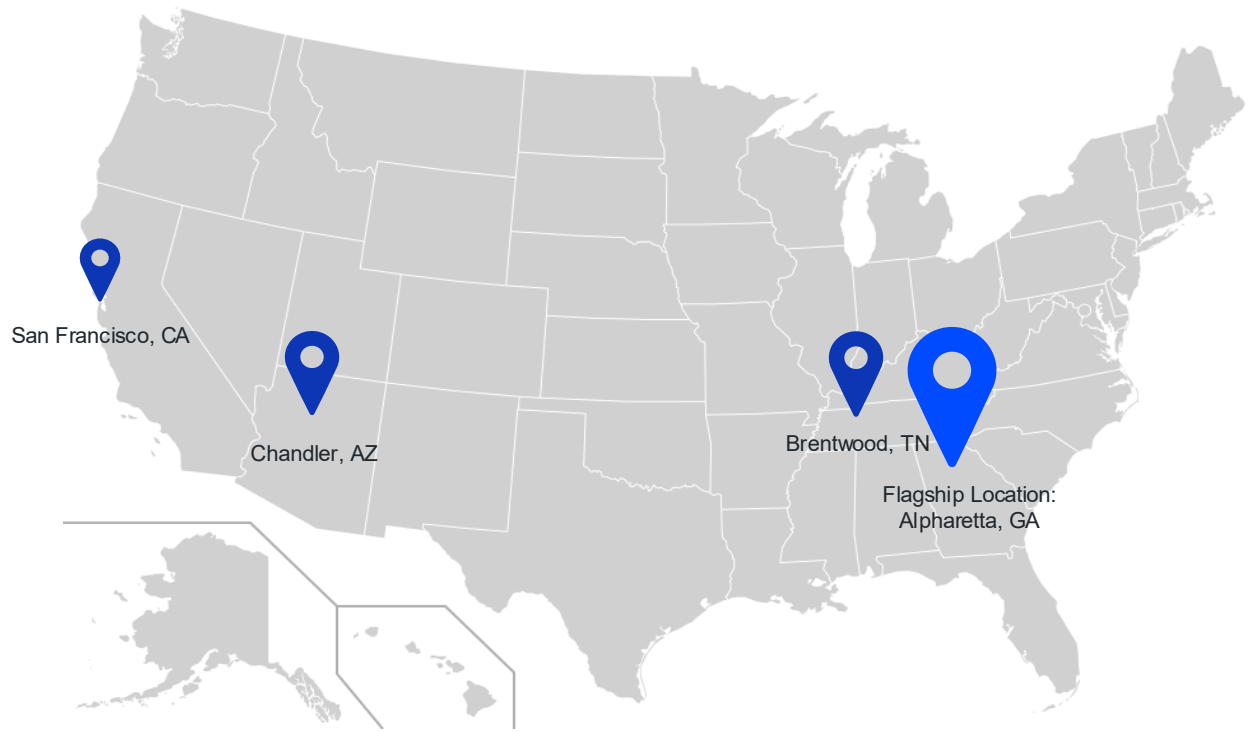
2400 Lakeview Parkway, Suite 400
Alpharetta, Georgia 30009

Additional Office Locations

750 Old Hickory Boulevard, Suite 110-1
Brentwood, Tennessee 37027

542 W. Chandler Boulevard
Chandler, Arizona 85225

201 Mission St., Suite 500
San Francisco, CA 94105



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